TRICARE Fundamentals Course

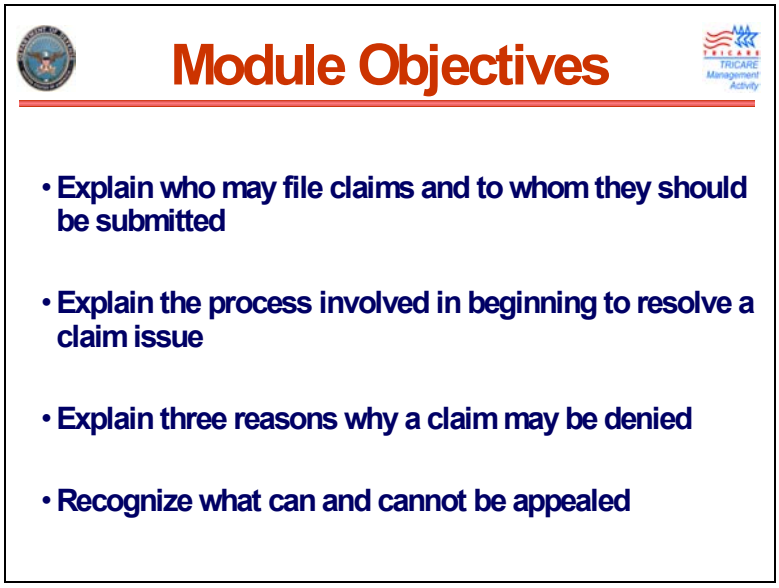
Module 14

Claims & Appeals

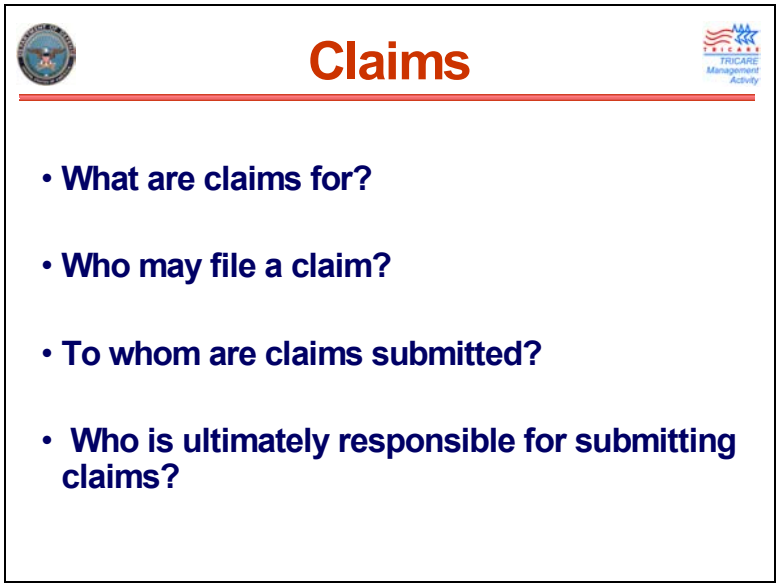
Participant Guide

References
32 CFR §§ 199.7, 199.10
OPM Part III, Chapter 13
MCSC Operations Manual 6010.49, March 2001, Chapter 8
TRICARE Reimbursement Manual, 6010.53, March 15, 2002, Chap 2, Addendum A

Module Objectives



Claims



What are Claims for?

Claims are filed to request reimbursement of monies for services or supplies provided by civilian sources of medical care which include:
- Physicians
- Hospitals
- Nursing facilities
- Pharmacies
- Medical suppliers
- Medical equipment suppliers
- Ambulance companies
- Laboratories
- Program for Persons with Disabilities providers
- Vendor pharmacies
- VA treatment facilities
- Other authorized providers

Who may File a Claim?

The person submitting the claim is either the provider of services or supplies, or the beneficiary:
- Any TRICARE-eligible beneficiary
  - A spouse, parent, or legal guardian of a minor or incompetent beneficiary may act on behalf of the beneficiary submitting a claim, unless otherwise specified. The beneficiary is ultimately responsible for submitting a claim.

- Any participating institution or professional provider approved under TRICARE for services or supplies provided to a beneficiary and receives payment directly from TRICARE
  - Institutional providers include hospitals and nursing facilities
  - Professional providers include an independent provider or group practice

To Whom are Claims Submitted?

Claims are submitted to the appropriate claims processor. There are two:
- PGBA (Palmetto Government Benefits Administrators)
- WPS (Wisconsin Physicians Service)

Note: The beneficiary submits claims to the claims processor responsible for the region where the beneficiary lives.

If beneficiaries send their claims to the managed care support contractor (MCSC), the MCSC will forward it to the appropriate claims processor. If a claim goes to the wrong claims processor, standards exist to forward the claim to the correct processor.

TRICARE Prime beneficiaries have the responsibility to make sure their enrollment and address are current so their claims go to the correct claims processor.

Claims Processing Procedures

Specific TRICARE claims processing procedures apply. The purpose of following those procedures is to ensure that:
- All claims for care received by TRICARE beneficiaries are processed in a timely manner, and
- The government-furnished funds are expended only for those services or supplies authorized by law and regulation.

The claims processor must respond to all claims to ensure that sufficient information has been submitted to determine whether:
- The beneficiary is eligible.
- The claim has been filed within the given time limits.
- The provider of services or supplies is authorized under the TRICARE Program.
- The service or supply provided is a benefit.
- The service or supply provided is medically necessary and appropriate or is an approved TRICARE preventive care service.
- The beneficiary is legally obligated to pay for the service or supply (except in the case of free services).
- The claim contains sufficient information to determine the allowable amount for each service or supply.

Resolving Claims Issues

- The Beneficiary Counseling and Assistance Coordinators (BCAC) and the Debt Collection Assistance Officers (DCAO) are the front line customer service persons who see or hear beneficiaries with claims issues.
- The following list should be considered and questions asked of the beneficiary when conducting an initial claim inquiry for the beneficiary:
  - Did the beneficiary bring in his or her explanation of benefits (EOB), summary payment voucher, or bill, or did they happen-by because they were close to the TRICARE Service Center (TSC)?
  - If the beneficiary states they never received an EOB, call the processing unit (PGBA or WPS) to determine if a claim was submitted by the provider. If not, call the provider to determine if and when the claim was sent to PGBA or WPS.
  - What is the current status or past status, or category of the beneficiary under TRICARE as displayed in the Defense Enrollment Eligibility Reporting System (DEERS)?

- What type of medical service was rendered i.e. medical appt, Rx, supplies?
- When was the date of the service?
- Was this service rendered as an inpatient or outpatient?
- If the EOB is available, look at the admin notes at the bottom to determine why the claim paid the way it did i.e. POS, no authorization on file, SSN is invalid, not a TRICARE benefit etc.

Note: BCACs and DCAOs should work with or try to work with one key individual, no more than three at PGBA or WPS to build rapport and maintain consistency in the communication process when researching/resolving beneficiary's claim(s) issues.

When does the Provider Submit Claims under TRICARE?

Prime

- If a beneficiary is enrolled in TRICARE Prime and is referred to a TRICARE Prime provider (one contracted by the MCSC), the provider submits the claim for the beneficiary.
- No outpatient or inpatient co-pays apply for active duty family members (ADFMs).
- Retirees and their eligible family members will pay the following:
  - Outpatient co-pays per visit
    - Outpatient $12
    - Emergency room $30
    - Mental health $25 ($17 for group visit)
  - Inpatient cost shares
    - Minimum of $25 or $11 per day
    - $40 a day for inpatient mental health

Extra

- If beneficiaries use TRICARE Extra, they are required to go to a network provider. Network providers are required to submit claims for beneficiaries.
- ADFMs will pay until deductible is met (E-4 and below: $50/individual and $100/family; E-5 and above: $150/individual and $300/family):
  - Outpatient cost share—15 percent of the negotiated fee
  - Inpatient cost share—greater of $25 or $13.32 per day
  - Mental health inpatient cost share—$20 per day
- Retirees and their eligible family members will pay the following after the deductible ($150/individual and $300/family)is met:
  - Outpatient cost share—20 percent of the negotiated fee
  - Inpatient cost share—whichever is less, $250 per day or 25 percent of institutional charges, plus 20 percent of professional charges if care is delivered in a TRICARE network hospital
  - Mental health inpatient cost share—20 percent of institutional and negotiated professional fees if care is delivered in a TRICARE network hospital

Standard

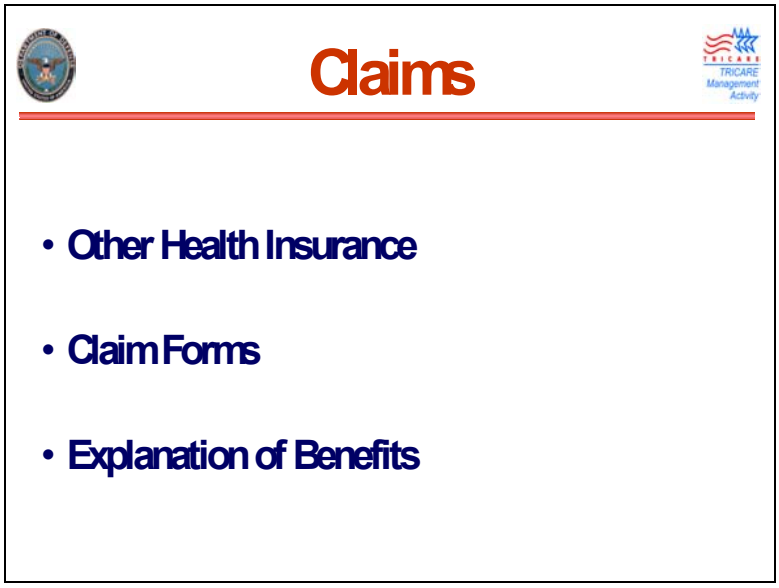
- If a beneficiary uses TRICARE Standard, the beneficiary is usually responsible for submitting his or her own claims to the appropriate claims processor.
- However, if the provider accepts assignment from TRICARE, it will submit claims for the beneficiaries.
- Those providers who accept assignment can do it on a case-by-case basis.
  - They usually accept assignment when the fees they charge match the amount they will be reimbursed.
  - The provider may request that the beneficiary pay 100 percent of the bill up front:
    - The maximum amount of reimbursement the provider will receive is 15 percent of the TRICARE allowable charge.
    - This is an example of a when beneficiary gets involved in balance billing
- ADFMs will pay until deductible is met (E-4 and below: $50/individual and $100/family; E-5 and above: $150/individual and $300/family):
  - Outpatient cost share-20 percent of the allowable charges for covered services
  - Inpatient cost share-greater of $25 or $13.32 per day
  - Mental health inpatient cost share—$20 per day
- Retirees and their eligible family members will pay the following after the deductible ($150/individual and $300/family) is met:
  - Outpatient cost share-25 percent of allowable charges for covered services
  - Inpatient cost share-whichever is less, $459 per day or 25 percent of allowable fees, plus 25 percent of professional charges
  - Mental health inpatient cost share-lesser of $164 per day or 25 percent of allowable fees plus 25 percent of professional charges

Responsibility for Filing

- It is ultimately the beneficiary's responsibility to make sure that claims get filed.
  - All claims must be filed within one (1) year of the date of service.
  - Beneficiaries should be encouraged to file as soon as possible.
  - Recommend to beneficiaries they ask their civilian providers if they will be filing the claims.

After claims are submitted, the beneficiary and provider (if the provider filed the claim) will each receive an EOB from the claims processor showing the services performed and the adjudication (or settlement of payments).

Claims



Other Health Insurance

Special circumstances exist when beneficiaries have other health insurance.

- If a beneficiary has other health insurance (OHI), the beneficiary or the provider must file a claim with that health insurance plan before filing with TRICARE.
- After the OHI has decided what it is going to pay, a claim can then be filed with TRICARE along with a copy of
  - The other health plan's payment determination
  - The itemized charges (bill)
- If beneficiaries do not tell TRICARE, the MCSC, the claims processor, or DEERS about their OHI, the claim could be delayed in processing or even denied.

Claim Forms

Beneficiaries need to be reminded they should not combine claims. That means, they should send a separate claim for a visit to a provider's office and separate claim for pharmacy or any other service or supply received. Also, they should submit a claim for each family member even though they may have visited the same provider on the same day.

Sent in by Beneficiaries or Family Members

- DD Form 2642, "CHAMPUS Claim Patient's Request For Medical Payment"
  - Submitted for services or supplies provided by civilian sources of medical care
  - If submitted by a provider, the form will be returned to the provider
  - Can be downloaded from the TRICARE Web site: www.tricare.osd.mil/claims/Dd2642.pdf
  - Can also be downloaded from the PGBA's Web site www.mytricare.com
  - Also available from TSC, TRICARE Claims Processor, BCAC, or Health Benefits Adviser (HBA)

Sent in by Beneficiaries or Family Members, or Provider

- DD Form 2527, "Statement of Personal Injury – Possible Third Party Liability"
  - Required to be submitted with DD Form 2642 when filing in instances in which a beneficiary's condition is accident-related, work-related, or both
  - Can be downloaded from the TRICARE Web site: www.tricare.osd.mil/ProviderHandbook/DD2527.pdf
  - Can also be downloaded from the PGBA's Web site www.mytricare.com
  - Also available from TSC, TRICARE Claims Processor, BCAC, or HBA

Sent in by Providers

- CMS 1500, "Health Insurance Claim Form"
  - To be used by professional providers
  - Can be downloaded from the TRICARE Web site: www.tricare.osd.mil/claims/1500-90.pdf
  - Can also be downloaded from the PGBA's Web site www.mytricare.com
  - Also available from TSC, TRICARE Claims Processor, BCAC, or HBA
- UB–92 (CMS 1450)
  - Used for inpatient or outpatient care from hospitals and other institutes
  - Can be download from the WPS website: www.tricare4u.com/apps/tricare2/pdfs/h1450.pdf
  - Not readily available at TSCs.

When Medical Care Received Overseas
- Beneficiary may submit a DD Form 2642 or DD Form 2520.
- Foreign providers are to submit DD Form 2520.
- No electronic version of DD Form 2520 is available.

Forms are also available from
- TSC, TRICARE Claims Processors, BCACs, or HBAs at the nearest MTF
- As a last resort, beneficiaries may also get claim forms by writing to TRICARE Management Activity, 16401 E. Centretech Parkway, Aurora, Colorado 80011-9066.

Items That May Need to be Submitted with Claims

(*Note:* the provider is submitting the claim, the beneficiary may be requested to obtain those items):
- Non-availability Statement (NAS) Authorization Number
- Referral Number
- Itemized list of charges for each service or supply
  - Must be on the provider's letterhead
- Itemized list of charges from pharmacy
  - Must be on pharmacy's letterhead or billing form
- Other health insurance
  - The health plan's payment determination or denial
  - EOB—same as payment determination or denial
- DD Form 2527, "Statement of Personal Injury – Possible Third-Party Liability"

How Soon After Submitting a Claim Should an EOB be Received?

- The beneficiary and the provider each should receive an EOB within 6 weeks of submitting a claim.
- The provider should be contacted if not received to determine if the claim was submitted in a timely fashion.
- Beneficiaries should be aware that EOBs are sent to the address they put on their claims forms or the address their provider has in their files.
  - Addresses on claim forms are considered the most recent and accurate.
  - DEERS should be kept updated, too.
- Some other reasons for a delay in receiving an EOB:
  - Wrong address
  - Claims returned if incomplete
  - Eligibility is being questioned
  - Diagnosis is missing
  - Third-Party Liability
  - Other health insurance
  - Complex claim requiring extensive review
  - Government directed delay, usually because the provider is being investigated or because of fraud

- The TRICARE Web site refers beneficiaries, who need assistance in completing their claim forms and understanding their EOBs, to their nearest TSC or their nearest BCAC or HBA.
- The claims processor can also assist beneficiaries with any questions pertaining to the EOB.
- If the claims issue has been sent to a collection agency, the beneficiary needs to seek assistance from the nearest DCAO.

Beneficiaries should be advised to carefully check each EOB they receive.
- They should make sure they compare their actual bills from the provider or service against the EOB.
- If they find a charge for something they never received, they should contact the claims processor.
- Example: A provider may inadvertently bill for annual check-up even if the beneficiary does not show for that appointment.

For Practice— How to Read an Explanation of Benefits

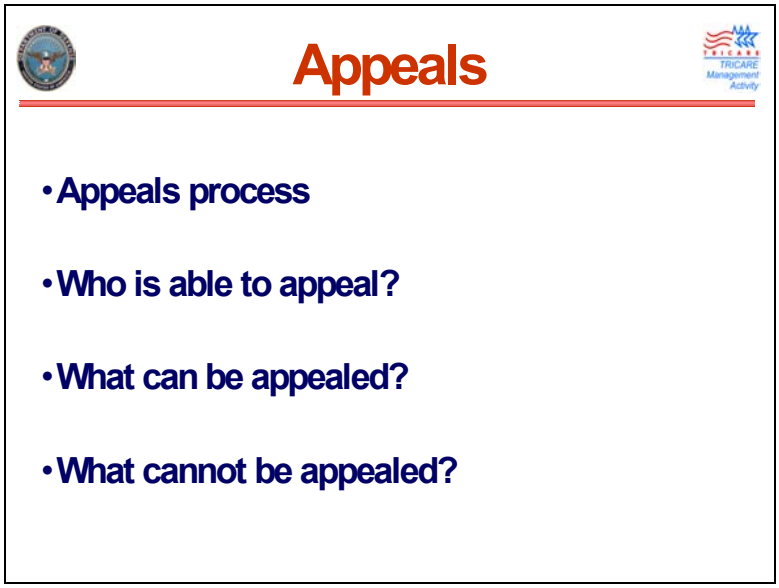
1. Mr. John Smith went to see a specialist.
a) Which TRICARE option does Mr. Smith have? How do you know?
b) Does he have other health insurance?
c) How much did TRICARE pay for the billed care he received?
d) Why did TRICARE pay this amount?

2. Mr. John Doe went to see a nurse practitioner who administers smoking cessation patches.
a) Which TRICARE option does Mr. Doe have? How do you know?
b) How much was billed by the provider?
c) How much did TRICARE pay?
d) Is the patient responsible for the billed amount, why or why not?

3. Mrs. Jane Smith went to see a network specialist.
a) Which TRICARE option does Mrs. Smith have?
b) The billed charge was $60.00. What is the TRICARE allowable charge?
c) What is her cost share?
d) What percentage of the TRICARE allowable charge did the patient pay?

4. a) Of the three scenarios above, who saved the most on out-of-pocket expenses?
b) Of the three scenarios above, who still owes money to the provider?
c) Which provider in the three scenarios above will not receive a check from the claims processing unit?

Appeals



Appeals Process

To appeal means to ask the TRICARE contractor or TRICARE Management Activity (TMA) for a review of the decision to deny a beneficiary's claim. The appeals process varies, depending on whether the denial of benefits involves:

- Medical necessity determination
- Factual determination
- Provider sanction

All initial denials and appeal denials explain how, where, and by when, to file the next level of appeal.

Medical Necessity Determinations

Medical necessity determinations are based solely on medical necessity:

- Whether, from a medical point of view, the care is appropriate, reasonable, and adequate for the beneficiary's condition
- Generally, determinations relating to mental health benefits are considered medical necessity determinations

There are procedures for expedited and non-expedited appeals.

- Expedited
  - There are expedited procedures for appealing decisions denying requests for
    - Preauthorization of services
    - Requests for continued inpatient stays
  - If an expedited appeal is available, the initial denial and appeal denial decisions will fully explain how to file an expedited appeal.
- Non-expedited
  - The beneficiary needs to send a letter to the managed care support contractor at the address specified in the notice of the beneficiary's right to appeal, included in their EOB or other decision:
    - The letter must be postmarked or received within 90 days of the date on the EOB or other decision.
    - It should include a copy of the EOB or other decision, and all supporting documents.
    - If the beneficiary does not have all of the supporting documents, he or she should state in the letter the intention to submit additional information
    - The beneficiary should make copies of the letter and all contents.
  - The MCSC will review the case and issue a reconsideration decision:
    - If the beneficiary disagrees with a reconsideration decision, the next level of appeal is the national quality monitoring contractor.
  - Send a letter to the national quality monitoring contractor:
    - The letter must be postmarked or received within 90 days of the date on the reconsideration decision.
    - A copy of the reconsideration decision and any supporting documents not previously submitted must be included in the letter.
    - If the beneficiary does not have all of the supporting documents, it should state in the letter that the beneficiary intends to submit additional information.
    - Beneficiary should keep copies of everything sent.
    - The national quality monitoring contractor will review the case and issue a second reconsideration decision.
  - If the amount in dispute is less than $300, the reconsideration decision by the national quality monitoring contractor is final:
    - If the beneficiary disagrees, and the disputed services are $300 or more, the beneficiary can request TMA to schedule an independent hearing.
    - The address for TMA is as follows:
      TRICARE Management Activity Appeals and Hearings Division
      16401 E. Centretech Parkway
      Aurora, Colorado 80011-9066

Factual Determinations

Factual determinations involve issues other than medical necessity. Some examples of factual determinations include the following:

- Coverage issues (i.e., determining whether the service is covered under TRICARE policy or regulation)
- Foreign claims and denial of a provider's request for approval as a TRICARE authorized provider

The appeal process for factual determinations includes the following:

- Send a letter to the MCSC, or to the address specified in the notice of the beneficiary's right to appeal, included in the beneficiary's EOB or other decision:
  - The letter must be postmarked or received within 90 days of the date on the EOB.
  - It must include a copy of the EOB or other decision and any supporting documents not previously submitted.
  - If the beneficiary does not have all of the supporting documents, it must be stated in the letter that the beneficiary intends to submit additional information.
  - The beneficiary should be encouraged to keep copies of anything sent.
- If the amount in dispute is less than $50, the reconsideration decision from the MCSC is final:
  - If the beneficiary disagrees, and if $50 or more is in dispute, the beneficiary may request a formal review from TMA.
  - If the beneficiary disagrees with a reconsideration decision, or with the initial determination from TMA, and if notice of the beneficiary's right to appeal any decision identifies TMA as the next level of appeal, the beneficiary may ask TMA to review the case again and issue a formal review decision.
- Send a letter to TMA:
  TRICARE Management Activity Appeals and Hearings Division
  16401 E. Centretech Parkway
  Aurora, Colorado 80011-9066
  - The letter must be postmarked or received within 60 days of the date on the initial determination or reconsideration decision.
  - The beneficiary should include copies of the determination or reconsideration decision, as well as any supporting documents not previously submitted.
  - If the beneficiary does not have all of the supporting documents, he or she should state the intention to submit additional information.
  - Encourage the beneficiary to keep copies of what is sent.
- TMA will review the case and issue a formal review decision:
  - If the amount in dispute is less than $300, the formal review decision by TMA is final.
  - If the beneficiary still disagrees, and the disputed services are $300 or more, the beneficiary can request TMA to schedule an independent hearing.

Provider Sanction Determinations

Provider sanction determinations occur when providers are expelled from TRICARE. Providers may be sanctioned by TRICARE because of the following:

- Failure to maintain credentials
- Provider fraud
- Abuse
- Conflict of interest or other reasons

Only the provider or his or her representative can appeal. If the sanctions are appealed, an independent hearing officer will conduct a hearing administered by the TMA Appeals and Hearings Division in Aurora, Colorado.

Who Is Able to Appeal?

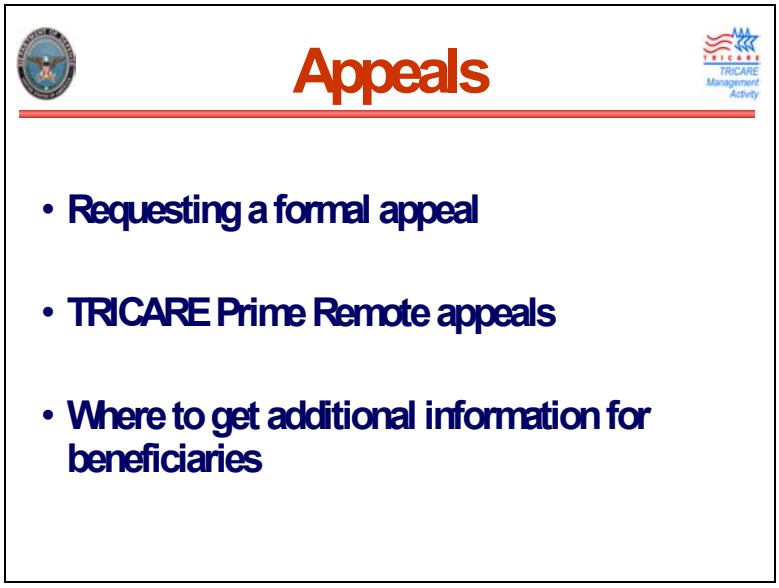
- Any TRICARE patient, or a parent or guardian of a patient who is under 18 years of age
- The guardian of a patient who is not competent to act in his or her own behalf
- A health care provider who has been
  - Denied approval
  - Suspended, excluded, or terminated as a TRICARE-authorized provider
- A health care provider who participates in TRICARE
  - Providers who participate in TRICARE accept the TRICARE-allowable charge as their full fee.
- A representative appointed in writing by a patient or provider
  - Certain individuals may not serve as representatives due to a conflict of interest:
    - An officer (member of a uniformed services legal office)
    - HBA
    - Employee of the United States (employee of a uniformed services legal office or an HBA)
  - Exception: that person is representing an immediate family member.
- The appealing party must be able to prove he or she is eligible for TRICARE benefits

What Can Be Appealed?

- The facts of the beneficiary's case
  - Diagnosis
  - Necessity to be an inpatient
- Denial of preauthorization for services, including mental health
- Termination of treatments or services that have been previously authorized

What Cannot Be Appealed?

- The amount that the TRICARE contractor determines to be the allowable charge for a particular medical service
  - The beneficiary may ask for an allowable charge review—not an appeal.
- The decision by TRICARE, or its contractors, to ask the beneficiary for more information before action is taken on the beneficiary's claim or appeal request
- Beneficiaries cannot appeal decisions relating to the status of TRICARE providers:
  - Although a beneficiary may want to receive care, or already has received care, from a particular provider, the beneficiary cannot appeal a decision that denies the provider authorization to be a TRICARE provider, or a decision that suspends, excludes, or terminates the provider.
  - The provider in question may appeal in his or her own behalf.
- Decisions relating to the beneficiary's eligibility as a TRICARE beneficiary
  - Eligibility is determined by enrollment in the DEERS:
    - Beneficiaries must appeal decisions regarding their eligibility through their branch of Service.



Requesting a Formal Hearing

A beneficiary wanting a formal hearing must send his or her request to the following:

TMA Appeals and Hearings Division
16401 E. Centretech Parkway
Aurora, Colorado 80011-9066.

The request must be:

- Postmarked within 60 days of the decision being appealed
- Include a copy of the decision being appealed and any supporting documents not previously submitted
- If the beneficiary does not have all of the supporting documents, the request should state that the intention to submit additional information.
- Encourage the beneficiary to keep copies of anything sent.

An independent hearing officer will conduct the hearing at a location convenient to both the requesting party and the Government. The hearing officer will issue a recommended decision, and the TMA director (or designee) or the Assistant Secretary of Defense for Health Affairs will issue the final decision.

TRICARE Prime Remote Appeals

In the event a request for specialty care is not approved, the active duty service member (ADSM) will be informed of the decision. The ADSM may appeal this decision by first contacting the Service Point of Contact (SPOC). ADSMs, their primary care manager, or other provider (if they do not have a primary care manager) may send additional written information or documentation to support the ADSM's request for specialty care to the SPOC.

If the request is denied on appeal, the ADSM may appeal one more time to the Surgeon General or senior medical officer of his or her respective Service. The address for this second appeal will be provided to the ADSM following a denial of the first appeal.

DoD Active Duty Service Members
ADSMs from the Army, Navy, Air Force, and Marine Corps may contact their SPOC at 1-888-MHS-MMSO (1-888-647-6676). Send written inquires to the following:

(Insert branch of Service) Point of Contact
Military Medical Support Office (MMSO)
P.O. Box 886999
Great Lakes, IL 60088-6999

United States Public Health Service (USPHS) and National Oceanic and Atmospheric Administration (NOAA) members may contact their Beneficiary Medical Program SPOC at 1-800-368-2777 option 2.

Coast Guard members may call 1-800-9HBA-HBA
(1-800-942-2422).

Where to Get Additional Information for Your Beneficiaries

If you cannot answer beneficiaries' questions about their denials, direct them to the following:

- The BCAC at the nearest MTF, if you are from a Reserve component unit
- BCAC at the regional Lead Agent office
- Regional TRICARE managed care support contractor
- The local TSC
- Or write to the TMA Appeals and Hearings Division, 16401 E. Centretech Parkway, Aurora, Colorado 80011-9066

Claims Processors

Region 1 – Northeast
Effective Date: For care received prior to or on August 31, 2004

Location	Name	Address	City	State	ZIP	Telephone
Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Northeastern West Virginia, Northern Virginia, Pennsylvania, Rhode Island, Vermont	PGBA	PO BOX 7011	Camden	SC	29020-7011	800-578-1294

Region 1 – Northeast transitioning to North Region
Effective Date: For care received on September 1, 2004 or after

Location	Name	Address	City	State	ZIP	Telephone
Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, and West Virginia	Health Net Federal Services, Inc. c/o PGBA, LLC /TRICARE	PO BOX 870140	Surfside Beach	SC	29587-9740	800-930-2929

Region 2 – Mid-Atlantic
Effective Date: For care received prior to or on June 30, 2004

Location	Name	Address	City	State	ZIP	Telephone
North Carolina, Southern Virginia	PGBA	PO BOX 7021	Camden	SC	29020-7021	800-493-1613

Region 2 – Mid-Atlantic transitioning to North Region
Effective Date: For care received on July 1, 2004 or after

Location	Name	Address	City	State	ZIP	Telephone
North Carolina, Southern Virginia	Health Net Federal Services, Inc. c/o PGBA, LLC /TRICARE	PO BOX 870140	Surfside Beach	SC	29587-9740	800-930-2929

REGION 3 – Southeast
Florida, Georgia, South Carolina
REGION 4 – Gulf South
Alabama, Mississippi, Tennessee (excluding the Ft. Campbell area),
Eastern Louisiana (includes New Orleans and Baton Rouge areas),
and a small portion in Arkansas adjacent to Millington, TN
Effective Date: For care received prior to or on July 31, 2004

For claims related to:	
Resource Sharing	PO BOX 7033, Camden, SC 29020-7033
Behavioral (Mental) Health	PO BOX 7034, Camden, SC 29020-7034
Active Duty	PO BOX 7031, Camden, SC 29020-7035
Program for Persons with Disabilities (PFPWD)	PO BOX 7036, Camden, SC 29020-7036
Adjunctive Dental	PO BOX 7037, Camden, SC 29020-7037
For all other claim categories:	

PGBA CHAMPUS CLAIMS
PO BOX 7031, CAMDEN, SC 29020-7031, 1-800-403-3950

For correspondence related to any claim category listed above:	
	PO BOX 7032, Camden, SC 29020-7032
For correspondence related to:	
Appeals	PO BOX 202002, Florence, SC 29502-2002
Provider Files/Certification	PO BOX 202004, Florence, SC 29502-2004
Medical Review	PO BOX 202005, Florence, SC 29502-2005
Utilization Management	PO BOX 202009, Florence, SC 29502-2009

Region 3 – Southeast
Region 4 – Gulfsouth transitioning to South Region
Effective Date: For care received on August 1, 2004 or after

Location	Name	Address	City	State	ZIP	Telephone
Alabama, Mississippi, Tennessee (excluding the Ft. Campbell area), Eastern Louisiana (includes New Orleans and Baton Rouge areas), and a small portion in Arkansas adjacent to Millington, TN	TRICARE South Region Claims Department	PO BOX 7031	Camden	SC	29020-7031	800-403-3950

Region 5 -- Heartland
Effective Date: For care received prior to or on June 30, 2004

Location	Name	Address	City	State	ZIP	Telephone
Illinois, Indiana, Kentucky, Michigan, Missouri (St. Louis area), Ohio, Tennessee (only those counties in Tennessee surrounding Ft. Campbell), West Virginia (except northeast tip of West Virginia), Wisconsin	PGBA	PO BOX 7021	Camden	SC	29020-7021	800-493-1613

Region 5 – Heartland transitioning to North Region
Effective Date: For care received on July 1, 2004 or after

Location	Name	Address	City	State	ZIP	Telephone
Illinois, Indiana, Kentucky, Michigan, Missouri (St. Louis area), Ohio, Tennessee (only those counties in Tennessee surrounding Ft. Campbell), West Virginia (except northeast tip of West Virginia), Wisconsin	Health Net Federal Services, Inc. c/o PGBA, LLC /TRICARE	PO BOX 870140	Surfside Beach	SC	29587-9740	800-930-2929

Region 6 -- Southwest
Effective Date: For care received prior to or on October 31, 2004

Location	Name	Address	City	State	ZIP	Telephone
Arkansas (except for service area of the Naval Hospital, Millington, Tennessee), Western Louisiana, Oklahoma, Texas (except William Beaumont catchment area in El Paso and Cannon AFB, NM service are ZIP codes that fall in Texas)	WPS	PO BOX 8999	Madison	WI	53708-8999	800-406-2832

Region 6 – Southwest transitioning to South Region
Effective Date: For care received on November 1, 2004 or after

Location	Name	Address	City	State	ZIP	Telephone
Arkansas (except for service area of the Naval Hospital, Millington, Tennessee), Western Louisiana, Oklahoma, Texas (except William Beaumont catchment area in El Paso and Cannon AFB, NM service are ZIP codes that fall in Texas)	TRICARE South Region Claims Department	PO BOX 7031	Camden	SC	29020-7031	800-403-3950

Region 7/8 – Central
Effective Date: For care received prior to or on September 30, 2004

Location	Name	Address	City	State	ZIP	Telephone
Arizona (except Yuma, CA)	PGBA	PO BOX 870026	Surfside Beach	SC	29587-8726	800-225-4816
Colorado	PGBA	PO BOX 870027	Surfside Beach	SC	29587-8727	800-225-4816
Idaho (except 6 counties in northern Idaho)	PGBA	PO BOX 870028	Surfside Beach	SC	29587-8728	800-225-4816
Iowa	PGBA	PO BOX 870029	Surfside Beach	SC	29587-8729	800-225-4816
Kansas	PGBA	PO BOX 870030	Surfside Beach	SC	29587-8730	800-225-4816
Minnesota	PGBA	PO BOX 870129	Surfside Beach	SC	29587-9729	800-225-4816
Missouri (except St. Louis area)	PGBA	PO BOX 870130	Surfside Beach	SC	29587-9730	800-225-4816
Montana	PGBA	PO BOX 870127	Surfside Beach	SC	29587-9727	800-225-4816
Nebraska	PGBA	PO BOX 870128	Surfside Beach	SC	29587-9728	800-225-4816
Nevada	PGBA	PO BOX 870033	Surfside Beach	SC	29587-8733	800-225-4816
New Mexico	PGBA	PO BOX 870032	Surfside Beach	SC	29587-8732	800-225-4816
North Dakota	PGBA	PO BOX 870031	Surfside Beach	SC	29587-8731	800-225-4816
South Dakota	PGBA	PO BOX 870131	Surfside Beach	SC	29587-9731	800-225-4816

Region 7/8 – Central
For care received prior to or on September 30, 2004

Location	Name	Address	City	State	ZIP	Telephone
Southwest Texas (William Beaumont and Cannon AFB, NM service areas)	PGBA	PO BOX 870133	Surfside Beach	SC	29587-9733	800-225-4816
Utah	PGBA	PO BOX 870132	Surfside Beach	SC	29587-9732	800-225-4816
Wyoming	PGBA	PO BOX 870126	Surfside Beach	SC	29587-9726	800-225-4816

Region 7/8 – Central transitioning to West Region
Effective Date: For care received on October 1, 2004 or after

Location	Name	Address	City	State	ZIP	Telephone
Arizona (except Yuma, CA) Colorado, Idaho (except 6 counties in northern Idaho), Iowa, Kansas, Minnesota, Missouri (except St. Louis area), Montana, Nebraska, Nevada, New Mexico, North Dakota, South Dakota, Utah, Wyoming	West Region Claims	PO BOX 77028	Madison	WI	53707-7028	888-874-9378

Region 9 -- Southern California
Effective Date: For care received prior to or on June 30, 2004

Location	Name	Address	City	State	ZIP	Telephone
Southern California (includes Yuma, Arizona)	PGBA	PO BOX 870001	Surfside Beach	SC	29587-8701	800-939-2929

Region 9 – Southern California transitioning to West Region
Effective Date: For care received on July 1, 2004 or after

Location	Name	Address	City	State	ZIP	Telephone
Southern California (includes Yuma, Arizona)	West Region Claims	PO BOX 77028	Madison	WI	53707-7028	888-874-9378

Region 10 -- Golden Gate
Effective Date: For care received prior to or on June 30, 2004

Location	Name	Address	City	State	ZIP	Telephone
Northern California	PGBA	PO BOX 870001	Surfside Beach	SC	29587-8701	800-930-2929

Region 10 – Golden Gate transitioning to West Region
Effective Date: For care received on July 1, 2004 or after

Location	Name	Address	City	State	ZIP	Telephone
Northern California	West Region Claims	PO BOX 77028	Madison	WI	53707-7028	888-874-9378

Region 11 -- Northwest
Effective Date: For care received prior to or on May 31, 2004

Location	Name	Address	City	State	ZIP	Telephone
Northern Idaho (Benewah, Bonner, Boundary, Kootenai, Latah, & Shoshone counties)	WPS TRICARE-NW	PO BOX 8929	Madison	WI	53708-8929	800-404-0110
Oregon	WPS TRICARE-NW	PO BOX 8929	Madison	WI	53708-8929	800-404-0110
Washington	WPS TRICARE-NW	PO BOX 8929	Madison	WI	53708-8929	800-404-0110

Region 11 – Northwest -- Alaska

Location	Name	Address	City	State	ZIP	Telephone
Active Duty Claims	PGBA/TRICARE	PO Box 870006	Surfside Beach	SC	29587-8706	800-930-2929
All Other Claims	PGBA/TRICARE	PO Box 870001	Surfside Beach	SC	29587-8706	800-930-2929

Region 11 – Northwest transitioning to West Region
Effective Date: For care received on June 1, 2004 or after

Location	Name	Address	City	State	ZIP	Telephone
Northern Idaho (Benewah, Bonner, Boundary, Kootenai, Latah, & Shoshone counties), Oregon, Washington, Alaska	West Region Claims	PO BOX 77028	Madison	WI	53707-7028	888-874-9378

Region 12 -- Hawaii
Effective Date: For care received prior to or on May 31, 2004

Location	Name	Address	City	State	ZIP	Telephone
Hawaii	PGBA	PO BOX 870001	Surfside Beach	SC	29587-8701	800-930-2929

Region 12 – Hawaii transitioning to West Region
Effective Date: For care received on June 1, 2004 or after

Location	Name	Address	City	State	ZIP	Telephone
Hawaii	West Region Claims	PO BOX 77028	Madison	WI	53707-7028	888-874-9378

Region 13 -- Europe
Effective Date: For care received after June 1, 1998

Location	Name	Address	City	State	ZIP	Telephone
Europe, Africa, Middle East	WPS	PO BOX 8976	Madison	WI	53708-8976	(608) 224-2727

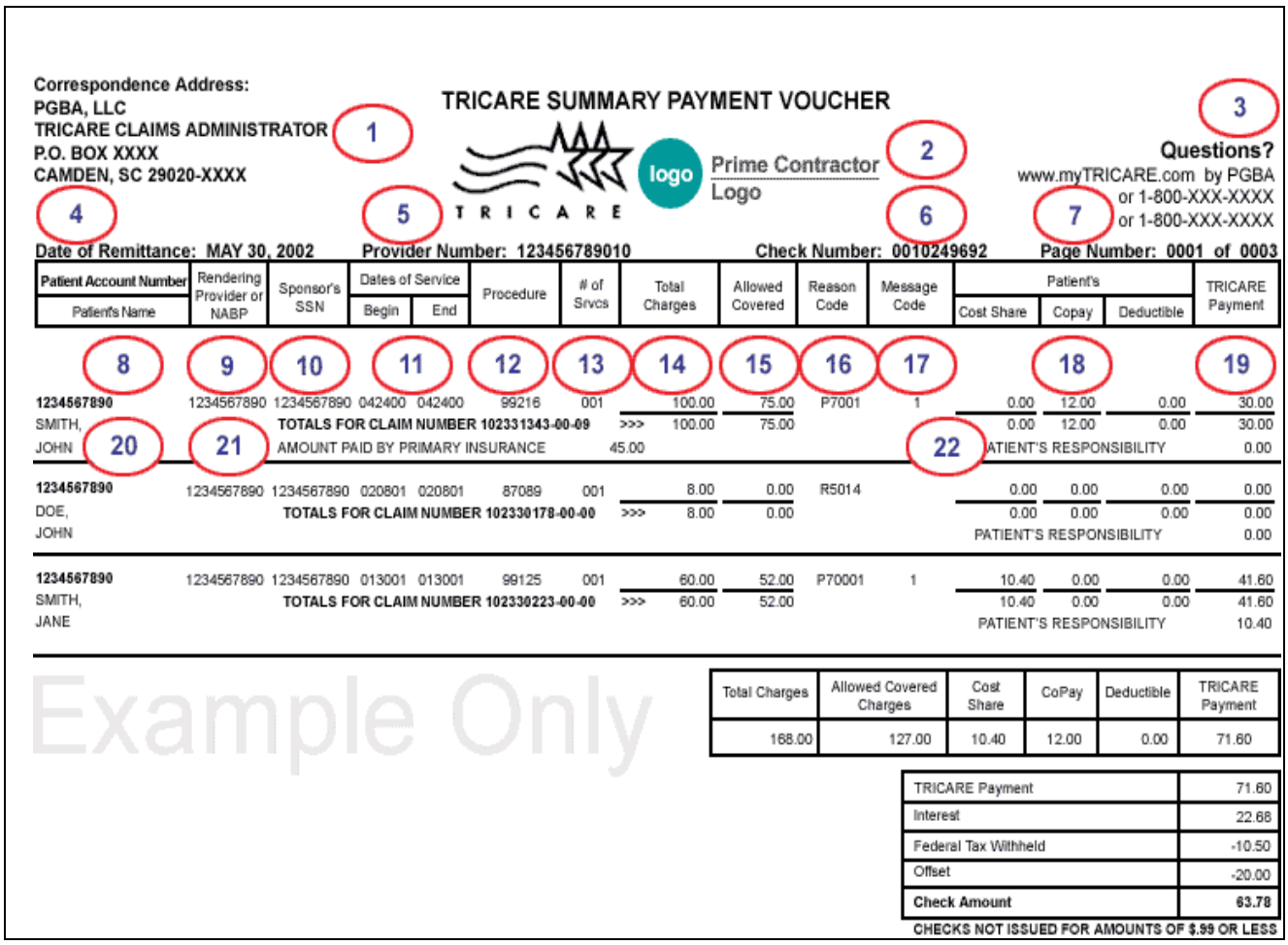
Region 14 -- WESTPAC
Effective Date: For care received after June 1, 1998

Location	Name	Address	City	State	ZIP	Telephone
Western Pacific (Japan, Guam, Korea, Thailand, etc.)	WPS	PO BOX 7985	Madison	WI	53707-7985	(608)301-2310

Region 15 -- Latin America, Canada, Puerto Rico & Virgin Islands
Effective Date: For care received after June 1, 1998

Location	Name	Address	City	State	ZIP	Telephone
All of Latin America, Canada, Bermuda, Virgin Islands	WPS	PO BOX 7985	Madison	WI	53707-7985	(608)301-2311
Puerto Rico	WPS	PO BOX 7985	Madison	WI	53707-7985	(800) 700-7104

How to read PGBA's TRICARE Summary Payment Voucher
(Also known as an EOB or Explanation of Benefits)



Correspondence Address:
PGBA, LLC
TRICARE CLAIMS ADMINISTRATOR
P.O. BOX XXXX
CAMDEN, SC 29020-XXXX

TRICARE SUMMARY PAYMENT VOUCHER

TRICARE

logo Prime Contractor Logo

Questions?
www.myTRICARE.com by PGBA
or 1-800-XXX-XXXX
or 1-800-XXX-XXXX

Date of Remittance: MAY 30, 2002 Provider Number: 123456789010 Check Number: 0010249692 Page Number: 0001 of 0003

Patient Account Number / Patient's Name	Rendering Provider or NABP	Sponsor's SSN	Dates of Service Begin	Dates of Service End	Procedure	# of Srvcs	Total Charges	Allowed Covered	Reason Code	Message Code	Patient's Cost Share	Patient's Copay	Patient's Deductible	TRICARE Payment
1234567890	1234567890	1234567890	042400	042400	99216	001	100.00	75.00	P7001	1	0.00	12.00	0.00	30.00
SMITH, JOHN	TOTALS FOR CLAIM NUMBER 102331343-00-09					>>>	100.00	75.00			0.00	12.00	0.00	30.00
	AMOUNT PAID BY PRIMARY INSURANCE					45.00					PATIENT'S RESPONSIBILITY			0.00
1234567890	1234567890	1234567890	020801	020801	87089	001	8.00	0.00	R5014		0.00	0.00	0.00	0.00
DOE, JOHN	TOTALS FOR CLAIM NUMBER 102330178-00-00					>>>	8.00	0.00			0.00	0.00	0.00	0.00
											PATIENT'S RESPONSIBILITY			0.00
1234567890	1234567890	1234567890	013001	013001	99125	001	60.00	52.00	P70001	1	10.40	0.00	0.00	41.60
SMITH, JANE	TOTALS FOR CLAIM NUMBER 102330223-00-00					>>>	60.00	52.00			10.40	0.00	0.00	41.60
											PATIENT'S RESPONSIBILITY			10.40

Example Only

Total Charges	Allowed Covered Charges	Cost Share	CoPay	Deductible	TRICARE Payment
168.00	127.00	10.40	12.00	0.00	71.60

TRICARE Payment	71.60
Interest	22.68
Federal Tax Withheld	-10.50
Offset	-20.00
Check Amount	**63.78**

CHECKS NOT ISSUED FOR AMOUNTS OF $.99 OR LESS

1. Correspondence address for PGBA, LLC, your region's TRICARE Claims Administrator.
2. The name and logo of the Prime contractor, the health service and support contractor for your TRICARE region.
3. The toll-free phone number/Web address for PGBA, your TRICARE Claims Administrator.
4. The date PGBA prepared this TRICARE payment voucher.
5. Social Security Number (SSN) or TIN of the provider who performed the services.
6. Number of the check issued as payment for the claim(s).

7. Number of this page followed by the total number of pages.
8. The patient's account number assigned by the provider's office and the patient's name.
9. SSN or TIN of the provider who performed the services or the provider's National Association of Boards of Pharmacy number.
10. The SSN of the military service member (active duty, retired or deceased).
11. Beginning and ending dates the services were performed.
12. CPT4 procedure code(s) or HCPCS equipment code(s) that identify the service(s) the provider performed.
13. The number of services the provider performed.
14. Total amount the provider billed for the services.
15. Amount TRICARE approves for the services.
16. This code corresponds to an explanation on the last page of how this claim was paid.
17. This code corresponds to a message on the last page that explains more about your claims payment.
18. Amounts subtracted from the total payment that are the patient's responsibility to pay.
19. Amount TRICARE has paid for the billed services.
20. If the claim was paid as DRG, the Diagnosis Related Group number would appear.
21. Total amounts for the claim and the amount other health insurance paid.
22. The amount the patient must pay the provider, including cost-shares, copayments, deductibles and non-covered charges.

Bottom of Form

TRICARE4U

TRICARE Northwest
P.O. BOX 7973
MADISON, WI 53707-7973

TRICARE SUMMARY
PAYMENT VOUCHER
B399161787 V

TRICARE EXPLANATION OF BENEFITS

Administered by: Health Net Federal Services, Inc.

This is a statement of the action taken on your TRICARE claim. Keep this notice of your records. If you have any questions regarding your claim payment please call the appropriate number:

Beneficiaries: 1-800-404-0110
Providers: 1-800-404-3117

COLONEL MUSTARD
309 CLUE LANE
SEATTLE WA 98063

WELBY, MARCUS MD
07/08/03

All Communications regarding these claims must reference the claim number.

	THIS IS NOT A BILL	

SPONSOR NO 399161787
PATIENT ACC # 55555555
SPONSOR COLONEL MUSTARD

PATIENT NAME			CLAIM NO					
COLONEL MUSTARD			2003189 53 49996					
PROVIDER	SERVICE DATES	PROC	MOD	NO	TYP	BILLED	ALLOWED	CODE
WELBY, MARCUS MD	02/01/03-02/01/03	81000		01	05	55.00	4.43	003
					TOTAL	55.00	4.43	

OTHER INS. ALLOWED	OTHER INS. PAID	REDUCTION DAYS	REDUCTION AMOUNT	PAID BY PATIENT
0.00	0.00	0	0.00	0.00

	DEDUCT	COST-SHARE/ COPAYMENT	TOTAL PAYABLE	INTEREST PAID	NET PAYMENT
**	0.00	0.00	4.43	0.00	4.43

REMARKS

PAYMENT HAS BEEN MADE TO THE PROVIDER OF CARE.
$1,146.53 HAS BEEN ACCUMULATED TOWARD THE CHAMPUS FISCAL YEAR CATASTROPHIC CAP OF $3,000.00 FOR THE FISCAL YEAR '03.
TOTAL BENEFICIARY LIABILITY IS $5.09.
ACCUMULATED INDIVIDUAL DEDUCTIBLE FOR FISCAL YEAR '03 IS $139.13.
ACCUMULATED FAMILY DEDUCTIBLE FOR FISCAL YEAR '03 IS $139.13.

CODE 003

IF YOU ARE NOT SATISFIED WITH OUR DETERMINATION, YOU HAVE THE RIGHT TO REQUEST A
REVIEW WITHIN 90 DAYS OF THE DATE OF THIS NOTICE. SEE ITEM FIVE ON REVERSE OF PAGE 1.

**********VOUCHER SUMMARY**********

TOTAL PAYMENT	NET PAYMENT
4.43	4.43

IMPORTANT NOTICE

1) THIS NOTICE CAN BE USED:

A. As a deductible certificate to show your providers the amount of the outpatient deductible met as of the date of this notice.
B. As a record of bills paid or denied (if you submitted other medical expenses not show on this form, you will receive a separate notice.)
C. To collect other insurance. This notice may be used to claim benefits from a secondary insurance policy. Since the insurance company may keep this notice, it is advisable that you keep a record of this information.

IF YOU NEED MORE INFORMATION:

- Check your TRICARE handbook.
- See the Health Benefits Advisor or Health Care Finder at the nearest Uniformed Services medical facility.
- Always give your Sponsor's Social Security number when writing about your claim.
- If inquiring about this claim, please provide the claim number located on the front of this form.
- Contact us at the telephone number shown on the front of this form.
- Written inquiries except Appeals (see #4) and Grievances (see #10) should be mailed to the following address:

  Foundation Health Federal Services
  TRICARE Services, Correspondence Unit
  P.O. Box 7973
  Madison, WI 53707-7973

2) TIME LIMIT FOR FILING CLAIMS:

For services received:	File Claims By:
1 Jan 93-31 Dec 93	31 Dec 94
1 Jan 94 & after	1 year after Date of Service

All claims for benefits submitted under TRICARE for dates of service prior to January 1, 1994 must be filed with the appropriate TRICARE contractor no later than December 31 of the calendar year immediately following the year in which the service or supply was provided. For services on and after January 1, 1994, all claims must be filed with the appropriate TRICARE contractor no later than one year from the date of service or, the date of discharge in the case of inpatient care.

If your claim was denied because it was not filed on time and you believe you were not at fault, contact us or your Health Benefits Advisor for assistance. In limited circumstances, exceptions may be made.

5) IF PAYMENT NOT BASED ON THE FULL AMOUNT BILLED:

The amount TRICARE may pay is limited by law to the **lowest** of:

A. The TRICARE Maximum Allowable Charge: i.e. the charge made 80 percent of the time by physicians or suppliers in the country for similar services during the base year adjusted by where the services were rendered; or
B. Prevailing charge; i.e. the charge made 80 percent of the time by physicians or suppliers in the state for similar services during the base year; or
C. The amount the provider actually charges for the service or supply; or
D. The fiscal year 1988 prevailing charge adjusted by the Medicare Economic Index (MEI); or
E. The discounted charge that a provider has agreed to accept under a special program approved by the Directory, TRICARE.

6) PATIENT'S SHARE OF THE COST FOR AUTHORIZED CARE:

Inpatient Benefits *See remarks on front.

Outpatient Benefits:	
Active duty family members of sponsor E-4 and below:	First $50 of allowable charges incurred by a patient each fiscal year (1 October-30 September) not to exceed $100 per family plus 20% of allowable charges after deductible has been paid.
Active duty family members of sponsor E-5 and above:	First $150 of allowable charges incurred by a patient each fiscal year (1 October-30 September) not to exceed $300 per family plus 20% of allowable charges after deductible has been paid.
Former spouses, non-active duty members and their families:	First $150 of allowable charges incurred by a patient each fiscal year (1 October-30 September) not to exceed $300 per family plus 25% of allowable charges after deductible has been paid.

Claim payments are subject to the provision that the beneficiary cost-share is collected by the provider. The provider's failure to collect the cost-share can be considered a false claim and/or may result in reduction of payment.

7) SPONSOR, PATIENT, OR DEPENDENT NOT ENROLLED OR NOT ELIGIBLE ON DEERS:

If the Defense Enrollment Eligibility Reporting System (DEERS) indicates that the sponsor, patient and/or

3) TYPE OF SERVICE CODES:

First Position:

A = Ambulatory surgery cost-shared as inpatient (Active Duty family members only)
I = Inpatient
M = Outpatient maternity care cost-shared as inpatient
N = Outpatient cost-shared as inpatient
O = Outpatient Care Other
P = Outpatient partial psychiatric hospitalization care cost-shared as inpatient

Second Position:

1 = Medical Care
2 = Surgery
3 = Consultation
4 = Diagnostic/Therapeutic X-Ray
5 = Diagnostic Laboratory
6 = Radiation Therapy
7 = Anesthesia
8 = Assistance at Surgery
9 = Other Medical Service
A = DME Rental/Purchase
B = Drugs
C = Ambulatory Surgery
D = Hospice
E = Second Opinion on Elective Surgery
F = Maternity
G = Dental
H = Mental Health Care
I = Ambulance
J = Program for Persons with Disabilities

4) YOUR RIGHT TO APPEAL THIS INITIAL DETERMINATION:

If you disagree with the determination on your claim, you have the right to request reconsideration. Your **SIGNED** written request must state the specific matter with which you disagree and **MUST** be mailed to the following address no later than ninety (90) days from the date of this notice. If the postmark on the envelope is not legible, then the date of receipt is deemed the date of filing. Include a copy of this notice. On receiving your request, all TRICARE claims for the entire course of treatment will be reviewed.

TRICARE Appeals
ATTN: APPEALS
P.O. Box 8370
Madison, WI 53708-8370

Should a beneficiary unknowingly receive services for non-TRICARE benefits, the beneficiary will not be held responsible for the charges.

dependent is not enrolled or eligible for TRICARE benefits, you should contact your Health Benefits Advisor or your service personnel office. Future claims will be denied if you are not enrolled in DEERS. If the claim was denied and the sponsor has recently gone on active duty, resubmit the claim with a copy of the duty orders and a photocopy of the patient's identification (ID) card or (parent's ID for dependent children under 10 years of age). If the sponsor is retired, resubmit the claim with the sponsor's retirement papers and a photocopy of the patient's (ID) card. If the sponsor is deceased, report to any service personnel office to get enrolled or call the appropriate number listed below.

8) IDENTIFICATION CARD (ID) OR ELIGIBILITY EXPIRED ON DEERS:

The Defense Enrollment Eligibility Reporting System (DEERS) indicates that the patient's ID card or eligibility has expired. To get a new ID card or extend eligibility, if sponsor is active duty, report at once to any parent service personnel office; if sponsor is retired or deceased, contact any service personnel office. If the claim was denied, when the patient obtains a current ID card, resubmit the claim with a photocopy of the new ID card (both front and back sides). In an emergency, call the appropriate number listed below.

FOR DEERS INFORMATION CALL:

CALIFORNIA……1-800-334 4162
HAWAII & Alaska 1-800 527-5602
ALL OTHER STATES…….. 1-800-538-9552

9) BENEFICIARY NOTICE:

Please review the services shown on the front side of this TRICARE Explanation of Benefits. If you find that payment consideration has been made for any services that you did not receive; or that services were provided by a health care professional that you did not see, please call the FRAUD AND ABUSE number at 1-800-977-6761.

10) TO FILE A GRIEVANCE:

If you become dissatisfied with the quality, timeliness or accessibility of care, you may file a grievance. Mail your written grievance to:

FHFS – QM Department
Attn: Grievances
3600 Port of Tacoma Road, Suite 505
Tacoma, WA 98424

TRICARE4U

TRICARE Northwest
P.O. BOX 7973
MADISON, WI 53707-7973

TRICARE SUMMARY
PAYMENT VOUCHER
P910567267989020000 V

TRICARE EXPLANATION OF BENEFITS

Administered by: Health Net Federal Services, Inc.

This is a statement of the action taken on your TRICARE claim. Keep this notice of your records. If you have any questions regarding your claim payment please call the appropriate number:

Beneficiaries: 1-800-404-0110
Providers: 1-800-404-3117

HOLY SMOKES HOSPITAL
2811 TIETON DRIVE
YAKIMA WA 98902-3761

HOLY SMOKES HOSPITAL
05/01/03

All Communications regarding these claims must reference the claim number.

	THIS IS NOT A BILL	

PATIENT ACC # 43039049309

PATIENT NAME	SPONSOR NO	CLAIM NO
PAUL BUNYAN	001122334	2003121 53 49992

SPONSOR NAME PAUL BUNYAN

PROVIDER	SERVICE DATES	DESCRIPTION	BILLED	ALLOWED	CODE
HOLY SMOKES HOSPIT	04/01/03-04/02/03	AUTHORIZE PRIV RM	300.00	0.00	236

DRG	DX1	DX2	DX3	DX4	PRC1	PRC2	PRC3	DSCH ST	YOB	SEX	OUTLIER
	DX5	DX6	DX7	PRC4	PRC5	PRC6					
	DX8	DX9									
000	56213							01	45	M	NONE

	PAID BY PATIENT	OTHER INS. PAID
**	0.00	100.00

	BILLED	COST-SHARE/ COPAYMENT	INTEREST PAID	NET PAYMENT
**	300.00	0.00	0.00	0.00

REMARKS

$1,394.27 HAS BEEN ACCUMULATED TOWARD THE CHAMPUS FISCAL YEAR CATASTROPHIC CAP OF $3,000.00 FOR THE FISCAL YEAR '03.

CODE 236

OUR RECORDS INDICATE THAT YOU HAVE TWO OR MORE HEALTH INSURANCES THAT ARE PRIMARY TO TRICARE. YOUR CLAIM WAS DENIED BECAUSE WE DID NOT RECEIVE EXPLANATIONS OF BENEFITS (EOBS) FROM ALL OF YOUR INSURANCES FOR THE CHARGES SUBMITTED TO TRICARE.

**********VOUCHER SUMMARY**********

TOTAL PAYMENT	NET PAYMENT
0.0	0.00

TRICARE4U Eob Back Text

IMPORTANT NOTICE

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TRICARE Appeals
ATTN: APPEALS
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Madison, WI 53708-8370

Should a beneficiary unknowingly receive services for non-TRICARE benefits, the beneficiary will not be held responsible for the charges.

dependent is not enrolled or eligible for TRICARE benefits, you should contact your Health Benefits Advisor or your service personnel office. Future claims will be denied if you are not enrolled in DEERS. If the claim was denied and the sponsor has recently gone on active duty, resubmit the claim with a copy of the duty orders and a photocopy of the patient's identification (ID) card or (parent's ID for dependent children under 10 years of age). If the sponsor is retired, resubmit the claim with the sponsor's retirement papers and a photocopy of the patient's (ID) card. If the sponsor is deceased, report to any service personnel office to get enrolled or call the appropriate number listed below.

8) IDENTIFICATION CARD (ID) OR ELIGIBILITY EXPIRED ON DEERS:

The Defense Enrollment Eligibility Reporting System (DEERS) indicates that the patient's ID card or eligibility has expired. To get a new ID card or extend eligibility, if sponsor is active duty, report at once to any parent service personnel office; if sponsor is retired or deceased, contact any service personnel office. If the claim was denied, when the patient obtains a current ID card, resubmit the claim with a photocopy of the new ID card (both front and back sides). In an emergency, call the appropriate number listed below.

FOR DEERS INFORMATION CALL:

CALIFORNIA……1-800-334 4162
HAWAII & Alaska 1-800 527-5602
ALL OTHER STATES…….. 1-800-538-9552

9) BENEFICIARY NOTICE:

Please review the services shown on the front side of this TRICARE Explanation of Benefits. If you find that payment consideration has been made for any services that you did not receive; or that services were provided by a health care professional that you did not see, please call the FRAUD AND ABUSE number at 1-800-977-6761.

10) TO FILE A GRIEVANCE:

If you become dissatisfied with the quality, timeliness or accessibility of care, you may file a grievance. Mail your written grievance to:

FHFS – QM Department
Attn: Grievances
3600 Port of Tacoma Road, Suite 505
Tacoma, WA 98424

Customer Service Commentary

It is your responsibility.
If you have answered the phone on behalf of TRICARE, you have accepted 100 percent responsibility. At least that's what the customer believes. So don't focus on "it's not my fault." Instead focus on "what can I do for you?"

I'm sorry does work.
In the customer's mind, it is your fault. Saying you're sorry won't fix the problem, but it definitely does help to defuse it immediately. Try it. You'll see.

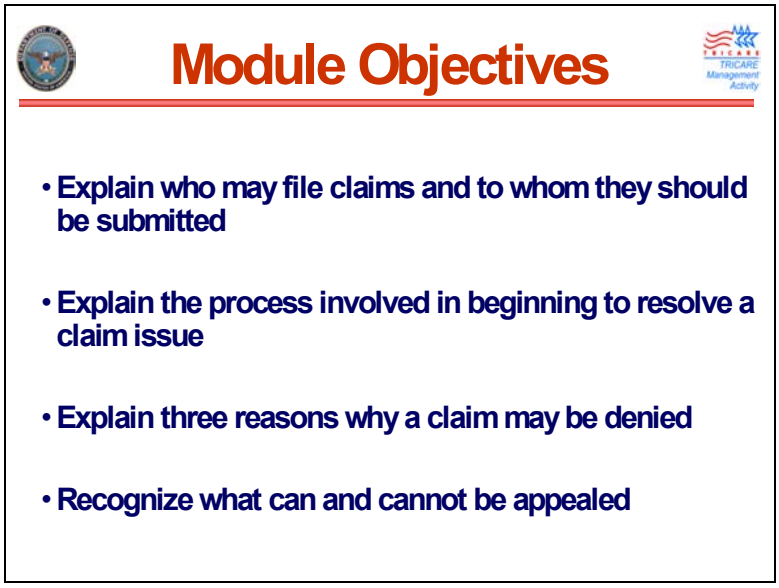
Empathize immediately.
When someone is angry or frustrated with TRICARE, the one thing they need is someone to agree with them, or at least feel they're being understood. Be careful, though: "I know how you feel" is not a good thing to say unless you have been through exactly what they have experienced. Try, "That's got to be so frustrating" or "What an unfortunate situation."

Immediate action is necessary to make a service recovery.
Don't make a customer wait for good service. Get whatever it is he or she needs immediately. Overnight service if it's necessary. That's recovery.

Ask what would make them happy.
In a few cases, the customer can be a most difficult one. If you have tried what you considered "everything," simply ask the customer: "What can I do to make you happy?" In most cases, it may be something you're able to do. You just may not have thought of it. So go ahead and ask.

Understand the true meaning of service recovery.
Service recovery is not just fixing the problem. It's making sure it won't happen again. It's listening to the customer. It's going above and beyond.

Summary


Module Objectives
• Explain who may file claims and to whom they should be submitted
• Explain the process involved in beginning to resolve a claim issue
• Explain three reasons why a claim may be denied
• Recognize what can and cannot be appealed